SF 4811-HCC (1-2002) Supersedes (1-2001) issue

UCI

Medical Insurance Premium Authorization Form

You must fill out the top section of this form if you are making a change to your medical plan which would require Sandia to increase or decrease your health care premium amount. If you choose to waive coverage*, please fill out the top portion of this form, mark the WAIVER box, read the Waiver of Medical Coverage section below, and sign both signature lines on this form.

Social Security Number	Name (Last, First, MI)				
Plan Type: ☐ TOP	☐ INTERMEDIATE	☐ BASIC	☐ CIGNA	☐ KAISER	☐ PRE-TAX ☐ AFTER-TAX
Enrollees (Check all that apply): ☐ EMPLOYEE or STUDENT EMPLOYEE ☐ SPOUSE CHILDREN: ☐ ONE ☐ TWO OR MORE	☐ NEW ☐ CHANGE ☐ CANCEL ☐ WAIVER (In order to waive medical coverage, you must sign below **as well as** read and sign the Waiver of Medical Coverage Statement.)			Benefits Department Use Payroll Effective Date: Salary Tier: Additional Information:	
Signature: X				Date:	

***Waiver of Medical Coverage**

To waive medical coverage for yourself and your dependents, you must fill out the information requested below and return it to the Benefits Department, 3341 at MS 1021. **This form must be received by the Benefits Department within 31 calendar days of your date of hire or the date of the mid-year election change event.**

I, _____ , SSN _____ , waive coverage for myself and all of my dependents in any of Sandia's medical plans (TOP, Intermediate, Basic, CIGNA, or Kaiser). I understand the benefit I am waiving and that Sandia is not responsible for any medical expenses incurred by me or my dependents during the period in which these benefits are waived. I also understand that my next opportunity to enroll in a Sandia medical plan will be during the Open Enrollment period for coverage the next calendar year or based on a mid-year election change event (see Note below).

Note: If you waive/drop coverage for yourself and your dependents because of other health insurance coverage and you and/or your dependents involuntarily lose eligibility for that coverage, you may be able to enroll yourself and your dependents during the plan year, provided that you request enrollment within 31 calendar days after your other coverage ends. In addition, if you gain a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 calendar days after the marriage, birth, adoption or placement for adoption.

_____ _____

Signature Date

* ☐ **Check here if you are covered as a dependent under another Sandian's medical insurance plan. Then, please write their name and SSN below so that we can update our database accordingly.**

Spouse's name: _____ Spouse's SSN: _____

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